the prescription drugs covered by the Medicaid program. I am concerned that a huge increase in costs will have a chilling effect on pharmaceutical research and development for the next generation of treatments, including those that aid the very patients with mental health conditions that we are attempting to help today. Mr. Speaker, I hope that you and the House conferees will work to address this issue in conference negotiations with the Senate.

After careful consideration, I urge my colleagues to join me in voting for H.R. 1424.

Mr. LANGEVIN. Mr. Speaker, I rise in strong support of the Paul Wellstone Mental Health and Addiction Equity Act of 2007, which I am proud to cosponsor. I know many people have worked hard to bring this important measure to the floor, including my friend from Minnesota, the co-chair of the Bipartisan Disabilities Caucus, Mr. RAMSTAD. Most of all, I would like to recognize the commitment and perseverance of my good friend and colleague from Rhode Island, PATRICK KENNEDY. PATRICK has been my good friend for many years, and I have watched him harness his passion and his knowledge to address the challenges faced by those with mental illness. He has raised awareness about a topic that had previously been considered taboo by the American people, using his own personal experiences to humanize the issue of mental health. I know that the people of Rhode Island admire his leadership, and I thank him for his tireless efforts.

Mental illnesses and substance abuse problems are at epidemic levels in this country. According to recent estimates, more than 35 million Americans experience the disabling symptoms of mental illness. Depression alone costs employers over $35 billion dollars a year in lost productivity, and that figure does not even factor in the multitude of other behavioral and psychological disorders that challenge our society on a daily basis. Substance abuse also directly affects an estimated 25 million Americans. An additional 40 million are indirectly affected once family members of abusers and the injured victims of intoxicated drivers are considered. Put simply, the social and monetary costs of these problems are astounding.

This bipartisan legislation makes tremendous strides in ending the inherent discrimination in our insurance system against patients seeking treatment for these illnesses. It permanently reauthorizes and expands the Mental Health Parity Act of 1996 to provide for equity in the coverage of mental health and substance-related disorders. It does not achieve equity by mandating that group health plans provide mental health coverage. However, if a plan chooses to offer coverage—as it rightfully should—then the coverage it offers must be no more restrictive in the financial requirements or treatment limits that are provided for medical or surgical disorders. This will mean equity in deductibles and co-pays, as well as in the frequency and number of visits. It will also establish parity for out-of-network coverage. In short, it will vastly expand coverage and access for those seeking treatment for their mental health.

Mental health parity is already available to members of Congress and over 8 million Federal employees under the Federal Employee Health Benefits Program, FEHBP, at minimal additional cost to the program. It is time that we extend this benefit to all Americans, and this legislation takes us considerably closer to that goal. I strongly urge my colleagues to vote in favor of this bill.

Mr. MCDERMOTT. Mr. Speaker, today is an historic day. Along with others, I have labored for a very long time to produce a comprehensive mental health parity bill. Without a doubt, our actions today will benefit real people in real ways. Many times we come to the floor to debate and vote on legislation that many Americans may wonder what is the relevance or the purpose? No one who has suffered a mental illness or has watched a family member suffer a mental illness will ask what is the relevance?

As a doctor and psychiatrist, I want to emphasize to my colleagues that this bill will make a genuine difference in the lives of the American people we serve. I know the suffering of mental illness. Not only do many patients still face the stigma of mental illness, but they also face discrimination in coverage.

Most Americans would be outraged if they heard that health plans charged higher copayments for cancer treatments or limited hospitals stays for those with heart diseases or denied care for diabetes. We would all be outraged. But, that is what we allow for mental illness.

We have heard a great deal about the costs of requiring mental health parity. What we hear very little about is the cost of not providing mental health parity. Many untreated mental illnesses can metastasize into serious physical and costly illnesses. Untreated depressions can result in heart disease. An untreated eating disorder can result in kidney failure. Yet, had we treated the mental illness we could have saved millions of dollars in costly care.

The issue of increasing costs of insurance is simply and categorically false. We know from the FEHBP experience that mental health parity has not resulted in significant costs. In fact, CBO has reported that H.R. 1424 would increase premiums by just two tenths of one percent. I would argue the longer term savings would offset any increase in premiums and that we will see a savings.

Access to mental health is simply access to quality primary care. It's key to preventing disease and improving outcomes. It simply makes no sense to treat the brain differently than the kidney or lungs or heart.

We have also heard a great deal about the use of the DSM–IV and scope of coverage. The use of DSM–IV is a tool for diagnosing mental illness and ensures that doctors, not insurance companies, define a mental illness. Some of my colleagues have argued that the use of DSM–IV will mean that plans must cover jet lag. These are not DSM diagnoses and refer to V Codes and not developed for the DSM.

My colleagues also argue that the use of the DSM–IV will prohibit plans from medical management. Again, my colleagues are wrong. As a practitioner, let me assure you that diagnosing and treating illness are very different things. Treatments can and will still be subject to medical necessity, like any other illness.

I think it is important for me to correct the record. Many of the speakers who addressed the House today are not health care professionals and have little understanding of mental illness. Yet, they claim to be experts on diagnosing and treating mental illness.

Finally, let me say a few words about the physician ownership offset. Just a couple of weeks ago, the administration sent to the Congress the Medicare 45 percent trigger recommendations. We have heard over and over again that Medicare spending is not sustainable and we need radical reforms. Yet, when we offer a small reform measure that will save more than $2 billion over 10 years, and protect patients from unnecessary care, some Members come to the floor to oppose. In fact, they argue that this physician ownership issue reduces choice or access. Who chooses to spend $2 billion more?

I understand that there may be some clinics that are providing quality care and we need to work to ensure that Medicare beneficiaries are not denied access. But, let's remember what we are doing. This is about closing a loophole to limit physician ownership of medical facilities to reduce over utilization and protect full service community hospitals. Many of these physician owned facilities do not staff an emergency department or an ICU. This is about protecting the integrity of the Medicare program. This is about controlling Medicare spending.

I strongly support H.R. 1424. Let's end this inhumane practice of discriminating against those with a mental illness. Let's make sure that when families pay premiums for health insurance coverage that they have the right to medically necessary coverage.

Mr. KIND. Mr. Speaker, I rise today in strong support of long overdue legislation that would equalize care for the millions of Americans suffering from mental health and substance-related disorders. More than 10 years after passing the Mental Health Parity Act, Congress now has the chance to finish the job it began and ensure that no Americans face discrimination in insurance coverage of mental health care.

Patients throughout the country struggle with the enormous financial costs of mental health and substance abuse treatments not covered by insurance. Many go without treatment, creating a burden on families, communities, and even our economy. Over 1.3 billion work days are lost annually due to mental disorders, more than stroke, heart attack, and cancer combined. In addition, employers face $135 billion in lost productivity each year due to untreated alcoholism and $31 billion due to untreated depression.

Enacting H.R. 1424 is important not only as a way to remove barriers to mental health and substance abuse care, however, but also as a way to remove the stigma long associated with these disorders. Equalizing care would send a strong message that the 57 million Americans suffering from mental health disorders and 26 million from chemical addiction should be treated no differently than individuals suffering from other medical conditions. I applaud the leadership and work of Representatives KENNEDY and RAMSTAD for their tireless efforts to bring this important legislation forward, and I am proud to give them my strong support.

In moving forward, it is my hope that the House and Senate can work together to find common ground so that mental health parity can be enacted. as part of this process, I would encourage negotiators to review the offsets used to pay for H.R. 1424, particularly the increase in the base Medicaid drug rebate level. I encourage Congress to consider the